DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-006

2. STATE: MAINE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
1/1/01

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 702, MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT (BIPA) OF 2000

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~PAGE 2 OF~~ ATTACHMENT 4.19-B, Pg. 1, 1a, 1b, 1c & 1d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
PAGE 2 OF ATTACHMENT 4.19-B

10. SUBJECT OF AMENDMENT:
CHANGES TO FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC PAYMENT PROVISIONS

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kevin W Concannon

13. TYPED NAME:
Kevin W. Concannon

14. TITLE:
Commissioner, Maine Department of Human Services

15. DATE SUBMITTED:
March 30, 2001

16. RETURN TO:
Eugene Gessow, Director
Bureau of Medical Services
#11 State House Station
Togus Building #205
Augusta, ME 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 30, 2001

18. DATE APPROVED:
[illegible]

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
[illegible]

21. TYPED NAME:
Ronald Preston

22. TITLE: Associate Regional Administrator
DMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

PAYMENT RATES FOR CARE AND SERVICES OTHER THAN INPATIENT HOSPITAL

1. Inpatient hospital services - see Attachment 4.19-A

2. a. Outpatient hospital services - Same as Attachment 4.19-A.

   b. Certified Rural Health Clinics -- The payment methodology for Certified Rural Health Clinics will conform to section 702 of the BIPA 2000 legislation, specifically to the BIPA 2000 requirements for Prospective Payment System (PPS). Certified Rural Health Clinics will be reimbursed on the basis of 100% of the average of their reasonable costs of providing Medicaid-covered services during FY 1999 and FY 2000, adjusted to take into account any increase or decrease in the scope of services furnished during FY 2001 (calculating the amount of payment on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each Certified Rural Health Clinic is entitled to the payment amount (on a per visit basis) to which the clinic was entitled under the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished during that fiscal year. Until the new payment rate is calculated according to this methodology, Certified Rural Health Clinics will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated. Newly qualified Certified Rural Health Clinics after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent area, or in the absence of such other clinics, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other clinics.

   c. Federally Qualified Rural Health Centers -- The payment methodology for Federally Qualified Rural Health Centers will conform to section 702 of the BIPA 2000 legislation, specifically to the BIPA 2000 requirements for Prospective Payment System (PPS). Federally Qualified Health Centers will be reimbursed on the basis of 100% of the average of their reasonable costs of providing Medicaid-covered services during FY 1999 and FY 2000, adjusted to take into account any increase or decrease in the scope of services furnished during FY 2001 (calculating the amount of payment on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each Federally Qualified Health Center is entitled to the payment amount (on a per visit basis) to which the center was entitled under the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished during that fiscal year. Until the new payment rate is calculated according to this methodology, Federally Qualified Health Centers will be paid at their current plan rate, which will be retroactively adjusted once the new payment rate is calculated. Newly qualified Federally Qualified Health Centers after fiscal year 2000 will have initial payments established either by reference to payments to other centers in the same or adjacent areas, or in the absence of such other centers, through cost reporting methods. After the initial year, payment shall be set using the MEI methods used for other centers.

3. Other laboratory and X-ray services - the same as under Physicians' services, Item 5.

4. a. Skilled Nursing Facility services(other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older. See Attachment 4.19 D.

   b. Early and Periodic Screening, Diagnosis and Treatment Services - The State agency will apply the rates currently in effect for the item of service provided, except the rates of payment for agencies participating in the EPSDT program under special agreements is made on the basis of a negotiated fee schedule.

   c. Family Planning Services and Supplies - The State agency will apply the payment rate as described in Attachment 4.19 A when provided by a hospital, and as described in Item 5 below when provided as physician's services. Family Planning Agencies are reimbursed on the basis of a fixed fee schedule.

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5. Physicians' Services - The State agency will apply a fee schedule, which will reflect "the intent of the (Maine) Legislature that the Department of Human Services establish a fee schedule governing reimbursement for physician's services that will result in an annual expenditure reduction of at least 10% over expenditures that would result if the current method of reimbursement is continued. In establishing this fee schedule the Department shall make an effort to consult with individual provider physicians or their representative associations." (Maine Public Law, Chapter 579, Section B-3 effective June 27,1977).

   The Fee Schedule - Insure that payment will not exceed the highest of the 75th percentile range of weighted customary charges in the same localities established under Title XVII during the calendar year preceding the fiscal year in which the determination is made.

PHYSICIAN FEEDBACK REPORT AND INCENTIVE AWARDS

ELEMENTS OF PHYSICIAN FEEDBACK REPORT

1. ACCESS (40 percent)

   a. Total number of unduplicated Medicaid recipients served per quarter year .
   b. Total number of health care providers accepting new Medicaid recipients.

2. UTILIZATION (30 percent)

   Emergency visit rate per quarter for physicians unduplicated Medicaid recipients per quarter.

3. QUALITY (30 percent)

   a. Preventive measures score higher.
   b. Comparison of Quality Indicators (QI) amongst specialty groups.

      Examples:

      Childhood immunization - percentage of children in the practice immunized by age 2 against DPT, polio, measles/mumps/rubella, type B influenza, and hepatitis B.

      Adolescent immunization - percentage of practice's children recipients who have had following immunization by age 13: second dose of measles/mumps/rubella, hepatitis B, tetanus/ diphtheria booster, and chicken pox.

      Prenatal Care - percentage of women in practice who delivered a baby in previous year and received prenatal care in the first trimester.

      Post-delivery checkup - percentage of mothers in practice who had a checkup within six weeks after delivery.

      Mammography - percentage of women in practice ages 52 to 69 who had a mammogram in previous year.

      Pap test - percentage of women in plan ages 21 to 64 who had a Pap test for cervical cancer in previous year.

      Board certification - percentage of practice board certified in appropriate discipline. The specific indicators utilized will be selected quarterly as necessary to obtain targeted quality of care evaluations. The same criteria shall be used amongst similar groups of physicians, i. e., Family Practitioners/General Practitioners, Internal Medicine, Pediatrics, etc.

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4. PATIENT SATISFACTION (per cent allocation to be determined in second year of physician assessment)

a. Percentage of recipients who change primary physician.
b. Percentage of recipients who report they are completely or very satisfied with their care.

DETERMINATION OF PHYSICIAN INCENTIVE AWARDS

The elements described above will be the basis for placing each participating Medicaid physician in a octal as follows:

GROUP 1	PERCENTILE	SIXTY PERCENT OF TOTAL AWARD (60%)
Octal 1	90 - 100	30% of group 1 award
Octal 2	80 - 89	20% of group 1 award
Octal 3	70 - 79	10% of group 1 award
GROUP 2	PERCENTILE	TWENTY-FIVE PERCENT OF TOTAL AWARD (25%)
Octal 4	60 - 69	10% of group 2 award
Octal 5	50 - 59	8% of group 2 award
Octal 6	40 - 49	7% of group 2 award
GROUP 3	PERCENTILE	FIFTEEN PERCENT OF TOTAL AWARD (15%)
Octal 7	30 - 39	10% of group 3 award
Octal 8	20 - 29	5% of group 3 award

NO AWARD FOR 0 - 19 PERCENTILE

b. PHYSICIAN (AND OTHER PRESCRIBERS) DIRECTED DRUG INITIATIVE (PDDI)

Elements Of Physician (And Other Prescribers) Directed Drug Initiative

Analysis of the first quarter's data will take place in May-June, 2000. Claims and subsequent payments, if any savings occur, will be issued 90-120 days following the end of each quarter. BMS will determine savings based upon actual prescribing patterns within drug categories for all practitioners aggregated together. Physicians and other prescribers will be compared to other prescribers in their specialty and will be evaluated based upon the use of cost saving therapeutic alternatives, frequency of generic prescribing, and reduction in use of brand name drugs for which there are therapeutically equivalent generics. Payment will occur if there are net savings in the specific group of drugs targeted or in a particular therapeutic class as long as health care outcomes are maintained or improved. Physicians and other prescribers who perform well under this program should expect to receive 40% of the net savings generated in the aggregate.

Methodology

Elements Of The Program Consist Of Two Pools Of Savings Available From The Initiative: 1) Specific Drug Category Savings, And 2) Non-Specific Drug Category Savings.

1) Within the Specific Drug Category Savings there are two means of distribution:

- The Specific Drug Category distribution, and the
- Specific Drug Category per month per member (PMPM) distribution.

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2) The methodology for the Non-Specific Drug Category is the PMPM distribution.

Any savings from the Specific Drug Category PMPM will be added to the Non-Specific Drug Category PMPM distribution.

These distributions are not dependent upon any one discrete claim or patient; rather they are reflective of the combined drug utilization profiles, drug outcomes and medical outcomes across the prescriber's entire patient panel. The health outcomes of the Medicaid population are protected since no savings are distributed to any participant unless maintained or improved quality is demonstrated.

Specific Drug Categories (SDCs) have appropriate therapeutically equivalent drugs with substantially different prices. Program costs for the Specific Drug Categories are monitored and savings are calculated within the categories. Relative pricing information and clinically appropriate patient/drug selection guidelines are shared with the prescribers for the Specific Drug Categories.

Initially, The List Of Specific Drug Categories Includes These Examples:

H2 Blockers/ Proton Pump Inhibitors
ACE Inhibitors/Calcium Channel Blockers/Beta Blockers and other antihypertensives
Statins
NSAIDS
Antidepressants
Antibiotics
Antihistamines
Nasal Steroids
Inhaled Steroids
Other categories will be added

Any net savings created within a Specific Drug Category created by a decrease in the value per unit cost will be redistributed to eligible prescribers according to the Specific Drug Category distribution formula described below. This distribution will occur regardless of whether any savings occur in other drug categories.

Two pools of savings dollars will be available from the Initiative: Specific Drug Category Savings and Non-Specific Drug Category Savings. Within the Specific Drug Category Savings there are two methods of distribution, the Specific Drug Category distribution and the Specific Drug Category PMPM distribution. The methodology for the Non-Specific Drug Category is the PMPM distribution. Approximately 85% of the savings is expected to come from Specific Drug Categories, and 15% from the Non-Specific Drug Categories. Any savings from the Specific Drug Category PMPM will be added to the Non-Specific Drug Category PMPM distribution. These distributions are not dependent upon any one discrete claim or patient; rather they are reflective of the combined drug utilization profiles, drug outcomes and medical outcomes across the prescriber's entire patient panel. The health outcomes of the Medicaid population are protected (ensured) since no savings are distributed to any participant unless maintained or improved quality is demonstrated. Conversely, it is important to note that even providers who do not create drug savings may receive an award if their quality medical or drug outcomes are superior to their peers.

For each specific drug category a baseline cost per unit prescribed will be calculated for all drugs in the category for an individual prescriber. Savings can not simply be redistributed on the basis of generic prescription volume since not all drug categories have generics. Furthermore, savings generated by changes within brand name drugs also need to be recognized.

If the individual prescriber's value/unit or cost for Period 2 is less than the aggregate value/unit for the initial period 1, they are eligible for a distribution, otherwise they are not eligible for a distribution. The distribution is 40% of the difference in cost per unit multiplied by the number of units.

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Drug Outcomes/Medical Outcomes Analysis:

In the first year of the Initiative, any prescriber who is eligible for a distribution share on the basis of generating savings is then subject to a drug outcome quality assessment. Each provider is compared to their peers across their relevant range of targeted conditions (ex. - family doctors, CHF, AFIB, DM, asthma, etc.). Any provider not performing above the mean or within one standard deviation below the mean would not receive a distribution.

The exception to this policy is when a provider who finishes more than 1 SD below the mean for their specialty has nevertheless improved on their own or their specialty's baseline drug outcomes. Starting with the second year (to allow for claims lag) similar performance thresholds will also apply for all relevant medical outcomes in order for an award to occur.

Savings from units prescribed are transformed to non-specific savings. Savings distributions in the Non-Specific Drug Category are also tied to quality outcomes. Distributions occur only if desired drug outcomes (DDO) or desired medical outcomes (DMO) are maintained or improved. Prescribers with better than average PMPM drug profiles receive a distribution unless DDO or DMO quality scores are greater than 1 standard deviation below the mean for their specialty. Prescribers with below average PMPM drug profiles do not receive a distribution unless their DDO or DMO is greater than 1 standard deviation above the mean for their specialty.

A third category of Quality Adjustment is the Dispensed As Written (DAW1) adjustment. Prescribers may restrict prescriptions to dispense only the brand name for a medication. The average DAW1 rate is calculated; an adjustment is made for prescribers with DAW1 rates greater than 1 standard deviation above the mean for their specialty. Additionally, adjustments need to be made for the size of the population eligible to take the medications through the use of the user/eligibility ratio. For conditions where increased utilization is desired, no adjustment is necessary, as, for example CHF and ACE Inhibitors. For certain over utilized medications, such as antibiotic use for upper respiratory infections or use of H2Bs/PPIs, an adjustment to the savings available for distribution is made based on the amount of increase in the user/eligibility ratio.

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